SENATE BILL No. 640

DIGEST OF INTRODUCED BILL

Citations Affected: IC 5-10-8.1; IC 27-8-5.7; IC 27-13-36.2.

Synopsis: Payment of clean insurance claims. Defines a "clean claim" for purposes of provider reimbursement under state employee health benefit plans, accident and sickness insurance policies, and health maintenance organization contracts. Provides specific locators that must be included in claims filed by health facilities. Allows state employee benefit plans, accident and sickness insurers, and health maintenance organizations to change locators in response to changes in federal law or regulations. Provides a procedure to determine whether to pay, deny, or suspend claims for payment submitted by health facilities and other providers. Requires the state employee benefit plan, accident and sickness insurer, or health maintenance

(Continued next page)

Effective: July 1, 1999.

Miller

January 22, 1999, read first time and referred to Committee on Health and Provider Services.

organization to make this determination and to pay each clean claim within 21 days after the claim is filed electronically and within 30 days after the claim is filed on paper. Requires the state employee health benefit plan, accident and sickness insurer, or health maintenance organization to pay interest to a provider who submits a clean claim that is paid later than the provided deadline. Describes the period during which interest accrues and provides the interest rate that applies.

Introduced

First Regular Session 111th General Assembly (1999)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 1998 General Assembly.

SENATE BILL No. 640

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 5-10-8.1 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]:

Chapter 8.1. State Employee Health Benefits; Provider Payment

Sec. 1. (a) Except as provided in subsection (b), as used in this chapter, "clean claim" means a claim submitted by a provider for payment under a health benefit plan that can be processed without obtaining additional information from the provider of the service or a third party. The term:

(1) includes a claim with errors originating in the administrator's claims processing system; and

(2) does not include a claim from a provider who is under:

(A) investigation for fraud or abuse; or

(B) review for medical necessity.

(b) "Clean claim", as the term applies to payments to a health

facility, means a claim submitted by a provider for payment that meets the following conditions:

(1) Contains the following locators:

(A) Type of bill.

(B) Coverage dates.

(C) Bill status.

(D) Revenue codes.

(E) Rate of payment.

(F) Service units.

(G) Total charges.

(H) Provider number.

(I) Third party prior payments.

(J) Estimated amount due.

(K) Covered individual number.

(L) Provider signature.

(M) Provider name.

(N) Number of covered days of service.

(O) Date of admission.

(P) Condition codes.

(Q) Occurrence codes and dates.

(R) Value codes and amounts.

(S) Third party liability payor name.

(T) Covered individual name.

(U) Admitting diagnosis.

(V) Attending physician ID number.

(2) Has correct and valid information for each of the locators required by subdivision (1).

(3) The covered individual for whom the claim is submitted is eligible for coverage under the health benefit plan on the date for which the service is billed.

(4) The administrator has approved the level of care for:

(A) the covered individual; and

(B) the facility;

for the dates for which the service is billed.

(5) The provider is eligible to render service on the date for which the service is billed.

(6) The claim does not duplicate a claim already paid.

The term includes a claim with errors originating in the administrator's claims processing system. The term does not include a claim from a provider who is under investigation for fraud or abuse, or under review for medical necessity.

(c) As used in this chapter, "covered individual" means an

individual who is:

(1) covered under a self-insurance program established under IC 5-10-8-7(b) to provide group health coverage; or

(2) entitled to services under a contract for health services entered into or renewed under IC 5-10-8-7(c).

(d) As used in this chapter, "health facility" has the meaning set forth in IC 16-18-2-167.

(e) As used in this chapter, "health benefit plan" means a self-insurance program established to provide group health coverage as described in IC 5-10-8-7(b), or a contract for health services as described in IC 5-10-8-7(c).

(f) As used in this chapter, "administrator" means:

(1) the state personnel department;

(2) an entity with which the state contracts to administer health coverage under IC 5-10-8-7(b); or

(3) a prepaid health care delivery plan with which the state contracts under IC 5-10-8-7(c).

(g) As used in this chapter, "provider" has the meaning set forth in IC 27-8-11-1.

Sec. 2. The administrator may adopt rules under IC 4-22-2 that add, delete, or modify the locators contained in section 1(b) of this chapter as necessary to conform with changes in federal law or regulation.

Sec. 3. (a) This section applies only to claims submitted for payment by health facilities.

(b) The administrator shall pay, deny, or suspend, in accordance with the following schedule, each claim submitted by a provider for payment under the health benefit plan:

(1) If the claim is filed electronically, within twenty-one (21) days after the date the claim is received by the administrator.

(2) If the claim is filed on paper, within thirty (30) days after the date the claim is received by the administrator.

(c) The administrator shall pay each clean claim.

(d) The administrator may deny or suspend a claim that is not a clean claim. If the administrator denies a provider's claim for payment, the administrator shall notify the provider of each reason the claim was denied.

(e) If the administrator suspends a provider's claim for payment under the health benefit plan, the administrator shall notify the provider of each reason the claim was suspended.

Sec. 4. (a) This section applies only to claims submitted for payment by health facilities.

(b) If the administrator:

(1) fails to pay a clean claim in the time required under section 3 of this chapter; or

(2) denies or suspends a claim that is subsequently determined to have been a clean claim when the claim was filed;

the administrator shall pay the provider interest on the health benefit plan allowable amount of the claim.

(c) Interest paid under subsection (b):

(1) accrues beginning:

(A) twenty-two (22) days after the date the claim is filed under section 3(b)(1) of this chapter; or

(B) thirty-one (31) days after the date the claim is filed under section 3(b)(2) of this chapter; and

(2) stops accruing on the date the administrator pays the claim.

(d) The administrator shall pay interest under subsection (b) at the same rate as determined under IC 12-15-21-3(7)(A).

Sec. 5. (a) This section does not apply to claims submitted for payment by health facilities.

(b) The administrator shall pay or deny each clean claim in accordance with section 6 of this chapter.

(c) The administrator shall deny or suspend each claim that is not a clean claim in accordance with subsection (d).

(d) The administrator shall, not more than thirty (30) days after the date a claim is received by the administrator, deny or suspend each claim that is:

(1) not a clean claim; and

(2) submitted by a provider for payment under the health benefit plan.

(e) If the administrator denies a provider's claim for payment under subsection (d) or section 6 of this chapter, the administrator shall notify the provider of each reason the claim was denied.

(f) If the administrator suspends a provider's claim for payment under subsection (d), the administrator shall notify the provider of each reason the claim was suspended.

Sec. 6. (a) This section does not apply to claims submitted for payment by health facilities.

(b) The administrator shall pay or deny each clean claim as follows:

(1) If the claim is filed electronically, within twenty-one (21) days after the date the claim is received by the administrator.

(2) If the claim is filed on paper, within thirty (30) days after

the date the claim is received by the administrator.

(c) If:

(1) the administrator fails to pay or deny a clean claim in the time required under subsection (b); and

(2) the administrator subsequently pays the claim;

the administrator shall pay the provider that submitted the claim interest on the health benefit plan allowable amount of the claim paid under this section.

(d) Interest paid under subsection (c):

(1) accrues beginning:

(A) twenty-two (22) days after the date the claim is filed under subsection (b)(1); or

(B) thirty-one (31) days after the date the claim is filed under subsection (b)(2); and

(2) stops accruing on the date the claim is paid.

(e) In paying interest under subsection (c), the administrator shall use the same interest rate as provided in IC 12-15-21-3(7)(A).

SECTION 2. IC 27-8-5.7 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]:

Chapter 5.7. Accident and Sickness Insurance; Provider Payment

Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" has the meaning set forth in IC 27-8-5-1.

(b) Except as provided in subsection (c), as used in this chapter, "clean claim" means a claim submitted by a provider for payment under an accident and sickness insurance policy issued in Indiana that can be processed without obtaining additional information from the provider of the service or a third party. The term:

(1) includes a claim with errors originating in the insurer's claims processing system; and

(2) does not include a claim from a provider who is under:

(A) investigation for fraud or abuse; or

(B) review for medical necessity.

(c) "Clean claim", as the term applies to payments to a health facility, means a claim submitted by a provider for payment that meets the following conditions:

(1) Contains the following locators:

(A) Type of bill.

(B) Coverage dates.

(C) Bill status.

(D) Revenue codes.

(E) Rate of payment.
(F) Service units.
(G) Total charges.
(H) Provider number.
(I) Third party prior payments.
(J) Estimated amount due.
(K) Insured number.
(L) Provider signature.
(M) Provider name.
(N) Number of covered days of service.
(O) Date of admission.
(P) Condition codes.
(Q) Occurrence codes and dates.
(R) Value codes and amounts.
(S) Third party liability payor name.
(T) Insured name.
(U) Admitting diagnosis.
(V) Attending physician ID number.

(2) Has correct and valid information for each of the locators required by subdivision (1).

(3) The insured for whom the claim is submitted is eligible for coverage under the accident and sickness insurance policy on the date for which the service is billed.

(4) The insurer has approved the level of care for:

(A) the insured; and

(B) the facility;

for the dates for which the service is billed.

(5) The provider is eligible to render service on the date for which the service is billed.

(6) The claim does not duplicate a claim already paid.

The term includes a claim with errors originating in the insurer's claims processing system. The term does not include a claim from a provider who is under investigation for fraud or abuse, or under review for medical necessity.

(d) As used in this chapter, "health facility" has the meaning set forth in IC 16-18-2-167.

(e) As used in this chapter, "insurer" means an insurance company issued a certificate of authority in Indiana to issue accident and sickness insurance policies.

(f) As used in this chapter, "provider" has the meaning set forth in IC 27-8-11-1.

Sec. 2. An insurer may add, delete, or modify the locators

contained in section 1(c) of this chapter as necessary to conform with changes in federal law or regulation.

Sec. 3. (a) This section applies only to claims submitted for payment by health facilities.

(b) An insurer shall pay, deny, or suspend, in accordance with the following schedule, each claim submitted by a provider for payment under the accident and sickness insurance policy:

(1) If the claim is filed electronically, within twenty-one (21) days after the date the claim is received by the insurer.

(2) If the claim is filed on paper, within thirty (30) days after the date the claim is received by the insurer.

(c) An insurer shall pay each clean claim.

(d) An insurer may deny or suspend a claim that is not a clean claim. If the insurer denies a provider's claim for payment, the insurer shall notify the provider of each reason the claim was denied.

(e) If an insurer suspends a provider's claim for payment under the accident and sickness insurance policy, the insurer shall notify the provider of each reason the claim was suspended.

Sec. 4. (a) This section applies only to claims submitted for payment by health facilities.

(b) If an insurer:

(1) fails to pay a clean claim in the time required under section 3 of this chapter; or

(2) denies or suspends a claim that is subsequently determined to have been a clean claim when the claim was filed;

the insurer shall pay the provider interest on the accident and sickness insurance policy allowable amount of the claim.

(c) Interest paid under subsection (b):

(1) accrues beginning:

(A) twenty-two (22) days after the date the claim is filed under section 3(b)(1) of this chapter; or

(B) thirty-one (31) days after the date the claim is filed under section 3(b)(2) of this chapter; and

(2) stops accruing on the date the office pays the claim.

(d) An insurer shall pay interest under subsection (b) at the same rate as determined under IC 12-15-21-3(7)(A).

Sec. 5. (a) This section does not apply to claims submitted for payment by health facilities.

(b) An insurer shall pay or deny each clean claim in accordance with section 6 of this chapter.

(c) An insurer shall deny or suspend each claim that is not a

clean claim in accordance with subsection (d).

(d) An insurer shall deny or suspend each claim that is:

(1) not a clean claim; and

(2) submitted by a provider for payment under the accident and sickness insurance policy;

not more than thirty (30) days after the date the claim is received by the insurer.

(e) If an insurer denies a provider's claim for payment under subsection (d) or section 6 of this chapter, the insurer shall notify the provider of each reason the claim was denied.

(f) If an insurer suspends a provider's claim for payment under subsection (d), the insurer shall notify the provider of each reason the claim was suspended.

Sec. 6. (a) This section does not apply to claims submitted for payment by health facilities.

(b) An insurer shall pay or deny each clean claim as follows:

(1) If the claim is filed electronically, within twenty-one (21) days after the date the claim is received by the insurer.

(2) If the claim is filed on paper, within thirty (30) days after the date the claim is received by the insurer.

(c) If:

(1) an insurer fails to pay or deny a clean claim in the time required under subsection (b); and

(2) the insurer subsequently pays the claim;

the insurer shall pay the provider that submitted the claim interest on the accident and sickness insurance policy allowable amount of the claim paid under this section.

(d) Interest paid under subsection (c):

(1) accrues beginning:

(A) twenty-two (22) days after the date the claim is filed under subsection (b)(1); or

(B) thirty-one (31) days after the date the claim is filed under subsection (b)(2); and

(2) stops accruing on the date the claim is paid.

(e) In paying interest under subsection (c), an insurer shall use the same interest rate as provided in IC 12-15-21-3(7)(A).

SECTION 3. IC 27-13-36.2 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]:

Chapter 36.2. Provider Payment

Sec. 1. (a) Except as provided in subsection (b), as used in this chapter, "clean claim" means a claim submitted by a provider for

payment for health care services provided to an enrollee that can be processed without obtaining additional information from the provider of the service or a third party. The term:

(1) includes a claim with errors originating in the insurer's claims processing system; and

(2) does not include a claim from a provider who is under:

(A) investigation for fraud or abuse; or

(B) review for medical necessity.

(b) "Clean claim", as the term applies to payments to a health facility, means a claim submitted by a provider for payment for health care services provided to an enrollee that meets the following conditions:

(1) Contains the following locators:

(A) Type of bill.

(B) Coverage dates.

(C) Bill status.

(D) Revenue codes.

(E) Rate of payment.

(F) Service units.

(G) Total charges.

(H) Provider number.

(I) Third party prior payments.

(J) Estimated amount due.

(K) Enrollee number.

(L) Provider signature.

(M) Provider name.

(N) Number of covered days of service.

(O) Date of admission.

(P) Condition codes.

(Q) Occurrence codes and dates.

(R) Value codes and amounts.

(S) Third party liability payor name.

(T) Enrollee name.

(U) Admitting diagnosis.

(V) Attending physician ID number.

(2) Has correct and valid information for each of the locators required by subdivision (1).

(3) The enrollee for whom the claim is submitted is eligible for payment for health care services on the date for which the service is billed.

(4) The health maintenance organization has approved the level of care for:

(A) the enrollee; and

(B) the facility;

for the dates for which the service is billed.

(5) The provider is eligible to render service on the date for which the service is billed.

(6) The claim does not duplicate a claim already paid. The term includes a claim with errors originating in the health maintenance organization's claims processing system. The term does not include a claim from a provider who is under investigation for fraud or abuse, or under review for medical necessity.

(c) As used in this chapter, "health facility" has the meaning set forth in IC 16-18-2-167.

Sec. 2. A health maintenance organization may add, delete, or modify the locators contained in section 1(c) of this chapter as necessary to conform with changes in federal law or regulation.

Sec. 3. (a) This section applies only to claims submitted for payment by health facilities.

(b) A health maintenance organization shall pay, deny, or suspend, in accordance with the following schedule, each claim submitted by a provider for payment for health care services provided to an enrollee:

(1) If the claim is filed electronically, within twenty-one (21) days after the date the claim is received by the health maintenance organization.

(2) If the claim is filed on paper, within thirty (30) days after the date the claim is received by the health maintenance organization.

(c) A health maintenance organization shall pay each clean claim.

(d) A health maintenance organization may deny or suspend a claim that is not a clean claim. If the health maintenance organization denies a provider's claim for payment, the health maintenance organization shall notify the provider of each reason the claim was denied.

(e) If a health maintenance organization suspends a provider's claim for payment for health care services provided to an enrollee, the health maintenance organization shall notify the provider of each reason the claim was suspended.

Sec. 4. (a) This section applies only to claims submitted for payment by health facilities.

(b) If a health maintenance organization:

(1) fails to pay a clean claim in the time required under section 3 of this chapter; or

(2) denies or suspends a claim that is subsequently determined to have been a clean claim when the claim was filed;

the health maintenance organization shall pay the provider interest on the lesser of the usual, customary, and reasonable charge for the health care services provided to the enrollee, or an amount agreed to between the health maintenance organization and the provider.

(c) Interest paid under subsection (b):

(1) accrues beginning:

(A) twenty-two (22) days after the date the claim is filed under section 3(b)(1) of this chapter; or

(B) thirty-one (31) days after the date the claim is filed under section 3(b)(2) of this chapter; and

(2) stops accruing on the date the office pays the claim.

(d) A health maintenance organization shall pay interest under subsection (b) at the same rate as determined under IC 12-15-21-3(7)(A).

Sec. 5. (a) This section does not apply to claims submitted for payment by health facilities.

(b) A health maintenance organization shall pay or deny each clean claim in accordance with section 6 of this chapter.

(c) A health maintenance organization shall deny or suspend each claim that is not a clean claim in accordance with subsection (d).

(d) A health maintenance organization shall deny or suspend each claim that is:

(1) not a clean claim; and

(2) submitted by a provider for payment for health care services provided to an enrollee;

not more than thirty (30) days after the date the claim is received by the health maintenance organization.

(e) If a health maintenance organization denies a provider's claim for payment under subsection (d) or section 6 of this chapter, the health maintenance organization shall notify the provider of each reason the claim was denied.

(f) If a health maintenance organization suspends a provider's claim for payment under subsection (d), the health maintenance organization shall notify the provider of each reason the claim was suspended.

Sec. 6. (a) This section does not apply to claims submitted for payment by health facilities.

(b) A health maintenance organization shall pay or deny each clean claim as follows:

(1) If the claim is filed electronically, within twenty-one (21) days after the date the claim is received by the health maintenance organization.

(2) If the claim is filed on paper, within thirty (30) days after the date the claim is received by the health maintenance organization.

(c) If:

(1) a health maintenance organization fails to pay or deny a clean claim in the time required under subsection (b); and

(2) the health maintenance organization subsequently pays the claim;

the health maintenance organization shall pay the provider that submitted the claim interest on the lesser of the usual, customary, and reasonable charge for the health care services provided to the enrollee or an amount agreed to between the health maintenance organization and the provider paid under this section.

(d) Interest paid under subsection (c):

(1) accrues beginning:

(A) twenty-two (22) days after the date the claim is filed under subsection (b)(1); or

(B) thirty-one (31) days after the date the claim is filed under subsection (b)(2); and

(2) stops accruing on the date the claim is paid.

(e) In paying interest under subsection (c), a health maintenance organization shall use the same interest rate as provided in IC 12-15-21-3(7)(A).

SECTION 4. [EFFECTIVE JULY 1, 1999] **(a) IC 5-10-8.1, as added by this act, applies to a self-insurance program or contract with a prepaid health care delivery plan that is established, issued, entered into, or renewed after June 30, 1999.**

(b) IC 27-8-5.7, as added by this act, applies to an accident and sickness insurance policy (as defined in IC 27-8-5-1) that is issued, entered into, delivered, or renewed after June 30, 1999.

(c) IC 27-13-36.2, as added by this act, applies to a health maintenance organization contract issued, entered into, delivered, or renewed after June 30, 1999.

(d) This SECTION expires July 1, 2004.